Policy Document
Digital Health (2026)

Executive Summary

The Australian Medical Students' Association (AMSA) strongly believes that with the advent of new and emerging technologies within the digital space and their impact on the health care system, relevant stakeholders should ensure clinicians and students are well educated and included, and that patient safety and privacy is upheld.

AMSA encourages the development of consistent research into the efficacy of digital health interventions to inform future development of this space. Digital research must remain patient-oriented and incorporate patient satisfaction as an outcome. Additionally, continuous efforts to improve digital inclusion, whether it be by the government or private stakeholders, are necessary to ensure equitable benefit from digital health interventions.

AMSA advocates for the continued improvement of the nationally adopted Electronic Health Records (EHR) and My Health Records (mHR) systems to ensure patient safety and to allow integrated access to best-practice frameworks and automated error warnings in reducing risks of medical errors and facilitating more timely intervention. Furthermore, governments and regulators should collaborate to develop national strategies that address Artificial Intelligence's (AI) emerging roles in healthcare. These strategies should encompass the transparent development of AI training databases, AI models, and their integration within healthcare settings.

AMSA believes the needs of vulnerable and underserved population groups, for example culturally and linguistically diverse (CALD) individuals, First nation's people, rural or regional communities, elderly peoples and people with disabilities or chronic conditions, be addressed in optimising alternative health delivery systems and technologies to ensure accessibility and functionality. In specific regards to First nation's peoples, Indigenous Data Governance and subsequent Data Sovereignty via collaboration with First nation communities should be implemented to address discriminatory Blameworthy, Aggregate, Decontextualised, Deficit, and Restricted data (BADDR) within digital health technologies.

AMSA advocates for the exploration into the potential for wearable technology to improve patient outcomes in clinical settings and/or enhance health surveillance. Additionally, telehealth and mobile health services should become a routine part of healthcare, bolstered by concurrent efforts to improve digital literacy and accessibility. For government-funded digital health platforms or medical records, having accessibility standards including screen readers, Auslan/video relay

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options, text-to-speech and speech-to-text functions should be required in the creation of these systems rather than as a forgotten feature added later when requested.

With the continual emergence of digital technologies and rising disparities in digital literacy and accessibility, clinicians and medical students should have access to appropriate education on these systems. Universities and health districts should ensure that curricula provide clinicians and students with a rigorous understanding of EHR, mHR, telehealth and mobile health delivery systems, AI and wearable technologies.

Policy Points

AMSA calls upon:

1. AHPRA and Medical Board of Australia to:

a. In relation to EHRs:
    i. Ensure the integration of EHRs as a standard practice across all healthcare facilities;
    ii. Ensure guidelines for secure and standardised sharing of patient information amongst practitioners to ensure patient safety and continuity of care; and
    iii. Monitor compliance with EHR adoption and provide guidelines for maintaining patient data privacy and security.
b. Encourage practitioners to engage in continued professional development pertaining to digital health.

2. The Australian Commonwealth, State, Territory, and Local Governments to:

a. Engage in consultations for the emerging roles of AI in healthcare and how to navigate this in the future;
b. Adopt a risk-stratified approach to AI governance, with higher standards of validation, transparency, monitoring and clinical accountability for AI systems that influence diagnosis, triage, treatment decisions or patient prioritisation;
c. Encourage the integration of telehealth as a routine part of healthcare; with an emphasis on addressing healthcare inequalities;
d. Take measures to improve educational status, health literacy and internet access of all Australians to improve digital health equity;
e. Collaboratively develop a national framework for EHR adoption, ensuring consistent standards and interoperability across regions;
f. Utilise the Lowitja Institute's Indigenous Data Sovereignty Readiness Assessment and Evaluation Toolkit to ensure Indigenous Data Sovereignty and Governance;
g. Ensure Australian Medical Students are informed of which digital health systems they will be expected to use throughout their careers; and
h. Prioritise workforce distribution to address geographical understaffing and not resort to telehealth as a permanent solution where in-person care is needed, such as acute mental health crises.

3. The Australian Digital Health Agency, on behalf of the Australian Government, to:

a. Develop health infrastructure, solutions and initiatives that continue to:
    i. Be secure;
    ii. Have standardised interoperability between healthcare providers and systems;

iii. Improve the visibility of health information for better consumer health outcomes and address health misinformation; and
iv. Have sustainable and cost-effective health services.

b. Lead the digitalisation of health systems in a manner that is accountable and transparent;
c. Develop and review its strategies and action plans, including but not limited to:
    i. Reflect Reconciliation Action Plans;
    ii. Leadership and Workforce Strategy;
    iii. Cyber Security Strategy;
    iv. Clinical Governance;
    v. Assessment framework for mHealth apps;
    vi. mHealth Apps Assessment Framework Options Report; and
    vii. National Healthcare Interoperability Plan.
d. Support further research into:
    i. Stratifying the advantages and disadvantages of telehealth for various patient groups, with an emphasis on patient-satisfaction related outcomes;
    ii. Determining which features of telehealth are most appreciated by patients, and which aspects require further improvement;
    iii. The benefits of telehealth on patient outcomes when used as an adjunct to in-person care, as opposed to as an alternative;
    iv. Addressing the barriers of inequitable investment into IT systems and its consequential effects on interoperability; and
    v. The defining factors of digital health systems in terms of use, delivery, and perception, particularly in the context of key demographics such as Aboriginal and/or Torres Strait Islander peoples.
e. Create nationalised telehealth guidelines for:
    i. Practitioners in Australia to determine the situations in which telehealth will be most useful;
    ii. Optimising triaging in telehealth; and
    iii. Creating telehealth platforms, in liaison with the Australian Digital Inclusion Agency.
f. Utilise the Lowitja Institute's Indigenous Data Sovereignty Readiness Assessment and Evaluation Toolkit to ensure Indigenous Data Sovereignty and Governance.

4. Developers for IT Platforms to:

a. Ensure technological systems used in healthcare maintain confidentiality and data security through appropriate governance and technological safeguards:
    i. Ensure patients are informed on the use of technological systems in their care;

ii. Ensure deidentification of data and safeguarding against data breaches; and
iii. Comply with Privacy Act of 1988.

b. Make information packs on models and clearly communicate risks to clinicians;
c. Recognise the main factors associated with patient satisfaction when designing and maintaining new telehealth platforms, including:
    i. Timely access to General Practitioners (GP) and acute care;
    ii. Improved accessibility;
    iii. Financial savings; and
    iv. Perceived decreased healthcare resource consumption, when designing new telehealth platforms.
d. Develop strategies that mitigate factors associated with patient dissatisfaction, including:
    i. Difficulties in expressing themselves;
    ii. A fear that “something may be missed”;
    iii. Limitations with technology;
    iv. Issues with obtaining prescriptions and pathology results; and
    v. Reduced confidence in their doctor.
e. Include accessible user interface options to improve accessibility to supplement sensory or cognitive deficits in older population groups, people with disabilities and/or limited digital literacy;
f. Include interpreter options to improve telehealth accessibility for people with a diverse language background;
g. Design systems in a way that both facilitates and encourages continuity of care for patients with known practitioners;
h. Adhere to established EHR standards and protocols to ensure compatibility and interoperability with existing EHR systems; and
i. Research the usage behaviour, uptake and success of mHealth apps in Australia.

5. Developers of AI Software to:

a. Ensure AI systems used in healthcare maintain confidentiality and data security through appropriate governance and technological safeguards:
    i. Ensure patients are informed on the use of AI Platforms in their care;
    ii. Ensure deidentification of data before health records are used in AI training, machine learning or research; and
    iii. Comply with Privacy Act of 1988.
b. Clearly communicate the intended use, limitations, risks, and data handling policies of AI systems to clinicians and consumers;
c. Develop AI systems in consultation with Australian healthcare professionals to ensure relevance and usability;
d. Ensure transparency regarding conflicts of interest including disclosure of external affiliations and data/model sources;

e. Implement independent review processes when appropriate to mitigate the influence of conflicts of interest on AI model development and clinical deployment;
f. Maintain appropriate human oversight for AI systems;
g. Implement strategies to identify and mitigate algorithmic bias, particularly for underserved/underrepresented/vulnerable groups;
h. Support ongoing evaluation and updating of AI systems to maintain clinical accuracy and relevance;
i. Remove BADDR Data associated with First Nations People people and ask consent for Indigenous data to be included into data systems:
    i. Obtain informed consent from knowledge holders and Elders when asking to use data and seek informed consent from them again if the data is to be used for a different purpose;
    ii. Knowledge holders have the right to withdraw consent and data from AI Software and programs at any point; and
    iii. Create clearly accessible pathways for knowledge holders and Elders to control whether data is used or not.

6. Healthcare professionals, including doctors, nurses and allied health staff, to:

a. Build data literacy by engaging in digital health and relevant cyber safety modules:
    i. Ensure that healthcare professionals are educated on, and can gain fully informed consent from patients in the responsible use of AI.
b. Develop awareness about the benefits of adjunctive telehealth amongst patients in underserved and vulnerable groups, including:
    i. Patients with mobility issues;
    ii. Aboriginal and/or Torres Strait Islander peoples;
    iii. Patients living in rural and remote areas;
    iv. Patients living with chronic diseases;
    v. Patients living with mental health conditions; and
    vi. CALD individuals.
c. Maintain awareness that patient satisfaction is related to:
    i. Timely access to GPs and acute care;
    ii. Positive patient outcomes;
    iii. High accessibility;
    iv. Cost efficiency; and
d. Develop understanding of privacy and confidentiality issues surrounding telehealth, so that patients may be adequately informed;
e. Support implementation of infrastructure within local practices to support video-conferencing as a viable telehealth alternative;
f. Research into and implement evidence-based mHealth apps that improve the management of conditions, particularly chronic disease; and

g. Remain knowledgeable of and provide personalised frameworks to patients for potential resources to use based on assessments of their level of health literacy.

7. Australian Medical Association and The Australian Medical Council to:

a. Build and maintain data literacy in clinicians through continuous professional development;
b. Advocate for medical students to engage in understanding the role and legality of AI systems in healthcare;
c. Advocate to raise awareness about the use and benefits of telehealth amongst health practitioners;
d. Utilise the Lowitja Institute's Indigenous Data Sovereignty Readiness Assessment and Evaluation Toolkit when engaging with data, research or policy pertaining to Aboriginal and/or Torres Strait Islander peoples; and
e. Regularly review Digital Health Policy Standards to reflect evolving clinical and technological advancements.

8. Australian Medical Education Providers (MEPs) to:

a. Build data literacy in medical students by integrating digital health and relevant cyber safety into the curriculum;
b. Facilitate opportunities to utilise AI systems appropriately in clinic and research;
c. Promote basic information system skills to increase transparency of privately deployed AI models;
d. Integrate comprehensive training on EHR usage and management into medical education curricula; and
e. Educate on the ethical issues resulting from AI, in medical education, patient care, and healthcare administration.

Background

INTRODUCTION

Australian healthcare workers, patients, students, and educators support a transformative digital health future; translating that into measurable outcomes remains the central challenge.[1,2] The Australian Government's Digital Health Blueprint 2023–2033 defines digital health as the "trusted, timely and accessible use of digital and data" for Australian healthcare; encompassing telehealth, EHR, mobile health applications, wearable devices, electronic prescribing, and AI clinical decision support tools.[3,4] This policy examines this broad scope using the best available evidence in Australia to build upon the existing National Digital Health Strategy (NDHS) and advocate for improvements.[5]

NDHS.

The Australian Digital Health Agency was established in 2016 to develop and implement the NDHS focusing on interoperability, health infrastructure security, cost-effective health services, improved vaccination rates, reduced duplication of testing, and greater access for rural Australians. The strategy's initiatives carry potential to improve patient outcomes, but there concerns for interoperability gaps, data privacy concerns, professional resistance, complex user interfaces, and EHR-related clinician burnout obstruct integration.[6,7] A 2026 policy review found that while rural geographic access is prioritised, strategies addressing affordability, digital literacy, and culturally safe care remain limited, and that digital health risks reinforce disparities across income, ethnicity, language, and First Nations communities. Governments, hospitals, patients, and healthcare professionals must drive proactive uptake of digital health systems to improve the quality, continuity, and efficiency of patient care in Australia.[6-8]

DIGITAL DETERMINANTS OF HEALTH (DDOH)

DDoH refers to how healthcare applications of digital technologies influence health equity through social, economic and cultural determinants of health.[9,10] Disadvantage in a social determinant can exacerbate disadvantage in digital determinants. Thus, it is imperative that implementation is grounded in values of equity and inclusion.[11-13]

Digital inclusion is influenced by availability of digital services, reliability of online content, and level of digital and health literacy.[10,14] Around 1 in 5 Australians face reduced digital inclusion, with rates of exclusion higher for people aged 75+ years (66.5%), those who did not complete secondary school (54.5%), and First Nations people (40.9%).[15] Vulnerable groups include people living with disabilities; geographically remote communities; CALD communities; and LGBTQIASB+ communities.[16] Despite improvement in Australian Digital Inclusion Index scores from 2023 to 2025, gaps persist highlighting need for more targeted support.[15]

Innovate Reconciliation Action Plan (RAP).
The Australian Digital Health Agency aims to consolidate progress made from the 2020-2021 Reflection Reconciliation Action Plan and implement the Innovate Reconciliation Action Plan (RAP) from 2023 to 2025. The RAP's key initiatives include;

- Building meaningful relationships with Aboriginal and Torres Strait Islander communities;
- Engaging with Indigenous digital health expert;
- Developing culturally tailored digital health resources and tools; and
- Addressing the digital divide to ensure equitable access to digital health technologies.[17]

The RAP's proactivity and cooperativity with various stakeholders (Aboriginal and Torres Strait Islander self-determination through partnerships with the National Aboriginal Community Control Health Organisation (NACCHO) and Affiliate) has facilitated effective delivery of culturally-appropriate training and information to improve meaningful use of MHR and other digital health services, with data from the ABS backing this growth.[17,18]

INDIGENOUS DATA SOVEREIGNTY

Indigenous Data "refers to information or knowledge, in any format or medium, which is about and may affect Indigenous peoples."[19] The Lowitja Institute defines Indigenous Data Sovereignty as "rights relating to the collection, ownership, and application of data about Indigenous peoples."[20] Implementing Indigenous Data Sovereignty is essential, as non-Indigenous control of First Nation's data has historically caused harmful deficit-based portrayals,[21,22] while providing limited benefit to First Nation's communities.[23] The major data discrepancies that perpetuate systemic discriminations are referred to as BADDR data.

Table. BADDR Data Outcomes vs Indigenous Data Needs

Dominant BADDR Data	Indigenous Data Needs
Blaming Data	**Lifeworld Data**
Too much data contrasts Indigenous/non-Indigenous data, rating the problematic Indigene against the normed Australian as the ubiquitous pejorative standard.	We need data to inform a comprehensive, nuanced narrative of who we are as people, of our culture, our communities, our resilience, our goals and our successes.
Aggregated Data	**Disaggregated Data**
Too much data is aggregated at the national and/or state level implying Indigenous cultural and geographic homogeneity.	We need data that recognises our cultural and geographical diversity to provide evidence for community-level planning and service delivery.
Decontextualised Data	**Contextualised Data**
Too many data are simplistic and decontextualised focusing on individuals and families outside of their social/cultural context.	We need data inclusive of the wider social structural context/complexities in which Indigenous disadvantage occurs.

Deficit, Government Priority Data	Indigenous Priority Data
Too much data reprises deficit-linked concepts that service the priorities of governments.	We need data that measures beyond problems and addresses our priorities and agendas.
Restricted Access Data	**Available Amenable Data**
Too much data is barricaded away by official statistical agencies and institutions.	We need data that are both accessible and amenable to our requirements.

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Implementations of Large Language Models in healthcare must identify and remove BADDR data from datasets and ask consent for First Nation's data to be included.[23,24]

Stakeholders engaging with First Nations data must enact Indigenous Data Governance, that is "the right of Indigenous peoples to autonomously decide what, how, and why Indigenous data are collected, accessed, and used".[25] A framework for Indigenous data governance calls for stakeholders to:

- Audit First Nation's involvement
- Provide mentorship of First Nation's individuals
- Reform policy to provide real decision making power

Indigenous Data governance is especially important for AI development, which poses a risk of homogenizing First nation's cultures and reinforcing information bias.[24] Stakeholders must allow First Nation co-governing bodies to evaluate Indigenous data sovereignty via the Indigenous Data Sovereignty Readiness Assessment and Evaluation Toolkit.[20]

Stakeholders should co-design health interventions involving First Nation's data with Aboriginal Community Controlled Health Organisations to ensure culturally safe data practices.[26,27]

DIGITAL INNOVATION AND ARTIFICIAL INTELLIGENCE

AI tools provide great potential to support medical education as well as aid medical research and innovation. The TGA regulates AI systems intended for clinical functions and publishes these devices, with primarily administrative tools generally falling outside this regulation.[28,29]

Current and Potential Implementation.

AI technologies are currently being implemented in healthcare. Automated clinical documentation tools like Heidi can improve efficiency and reduce administrative burden. These systems utilise proprietary algorithms and clinician labelling for accuracy with safeguards to protect patient confidentiality. Many maintain transparent public policies to support informed decision making.[30] Ongoing consultation with clinicians is required to ensure relevancy and accuracy.

AI assisted triage systems can support prioritisation of care in high demand environments, and can use pattern recognition based on data for medical imaging. The effectiveness of such tools depends on high quality scans annotated by professionals, showing potential in first line detection in resource constrained settings.[31]

AI translation tools can support communication in emergency settings where interpreters are unavailable.[32] The accuracy of these systems varies for languages with fewer speakers and challenges persist regarding practicality.[33] AI enabled dictation devices improve accessibility for clinicians and patients with disabilities through voice documentation and information processing.[34]

Challenges.
Machine learning systems can exhibit bias regarding demographic characteristics such as gender and ethnicity, necessitating diverse datasets in training and ongoing evaluation. The “black box” nature of AI systems also reduces transparency and accountability.[35] Cloud-based systems introduce privacy and data breach risks, whilst locally hosted AI systems improve data security by reducing reliance on external infrastructure.[36]

Risk stratification is needed when implementing AI in healthcare with administrative AI systems generally posing lower risk compared to systems used for triage, diagnosis and treatment. In a study 53% of users reported a high success whilst using AI for clinical documentation compared only 38% for diagnosis and early sepsis detection highlighting the need for rigorous validation and human oversight in critical situations.[37]

DIGITAL HEALTH AND ARTIFICIAL INTELLIGENCE IN MEDICAL EDUCATION

Digital health is increasingly embedded within healthcare systems, including telehealth, EHR and AI.[38] As doctors continue to utilise digital health technologies, medical education must evolve to ensure practitioners use them appropriately.[39,40] Evidence suggests that while students and educators recognise digital health’s importance, there remains a need for a “nationally coordinated strategy to expand” Digital Health Education (DHE).[38,41-43]

AI learning systems, generative AI, and clinical automation tools are increasingly used in imaging, documentation and triage.[44,45] These technologies may improve efficiency and accessible care when aptly governed, but pose risks including algorithmic bias, privacy breaches, misinformation, and overreliance.[46]

Benefits of Digital Health Education.
Embedding DHE within medical curricula ensures sound operation of EHR systems, telehealth communication, and digital workflows with competence.[47-51] Responsible AI education will support students to engage with innovations in healthcare and aid the identification of inaccurate or biased AI.[52] Primarily, AI is a decision-support tool rather than a replacement for clinical reasoning, professionalism, or patient-centred care.[53]

Challenges and Risks.
Implementation of standardised digital health education into medical curricula faces several barriers.[38,39,54] Institutions' capabilities to deliver education may vary due to educators lacking confidence and/or resources in teaching digital tools, propagating inequity.[55]

Future Directions.
Medicine must adopt a longitudinal approach to digital health education, embedding both practical and ethical competencies as seen in the ADHA Digital Health Trainer Toolkit.[56]

TELEHEALTH IN AUSTRALIA

Telehealth is a permanent feature of Australian healthcare post-Covid, utilised by 22.5% of people in 2024-25.[56-59] Changes in 2026 require practitioners to collect and retain written consent prior to filing for Medicare benefits which can affect accessibility.[60]

Benefits.
Telehealth improves efficiency and equity, particularly for rural and remote populations.[61,62] First Nations peoples and patients living with chronic disease experience improved mortality and quality of life.[63,64] Telehealth decreasing resource consumption, patient-costs, and failure-to-attend rates, though system-benefits remain unproven in Australian reviews.[65-72]

Clinician and Public Perception.
Patients are increasingly satisfied with telehealth, though some fear physical cues may be missed and find challenges with self-expression.[73,74] Satisfaction is lower among older patients, those reporting lower educational qualifications or health literacy, and those lacking internet access. Providers report high satisfaction but raise concerns about misuse, highlighting effective triage systems to allocate resources.[75,76]

Disadvantages.
Disadvantages include inability to read non-verbal cues, connectivity issues, privacy concerns, and equity gaps, which are significant in mental health, suicide risk, and domestic violence contexts.[77-79] Barriers include technology literacy, interface accessibility and data privacy.[80-81]

CALD populations experience reduced access and disempowerment from reliance on interpreters, addressable through language options, practitioner training, and culturally specific platforms.[82-89] First Nations peoples may experience lower-quality care due to cultural safety issues, addressable by culturally sensitive platforms developed with local groups and an initial in-person visit policy.[77,90]

Telehealth risks reducing continuity of care, but when implemented appropriately alongside in-person care can improve practitioner reach.[59,91-93]

Video vs Audio.
Video consultations offer clinical advantages (fewer medication errors, greater diagnostic and decision-making accuracy),[94] while telephone consults suit those with poorer connectivity or digital literacy. No major differences in patient satisfaction exist where video is not required for patient assessment.[95,96]

MOBILE HEALTH

Mobile health (mHealth) technology is growing in number of applications. The Department of Health and Aged Care applications include Hearing Services Program, myAssessor application for Aged Care assessments, and Primary Healthcare Network locator.[97]

mHealth has been introduced in the management of chronic diseases. A study on the feasibility of mHealth app prescriptions by GPs in Australia showed confidence in prescribing them doubled over the course of the study and described its use as highly acceptable.[98] A pilot study in SMS self-management reminders for Type 2 Diabetes Mellitus showed improved patient engagement and satisfaction, and reduced pressure and increased cost effectiveness for practices due to automation only requiring one full-time equivalent care manager per 300 enrolled patients.[98]

Previous barriers to mHealth uptake include security and responsibility of data sharing, legal regulation and benefits under the Medicare Benefits Schedule (MBS).[99] A study on barriers to prescribing mHealth Apps from GP perspectives suggests uptake was hindered by generational differences in technology use, lack of knowledge and limited access to trustworthy app recommendations.[100] mHealth can connect rural communities providing access to patient records and medical database applications, including Merck Index, MIMs and UpToDate to ensure safe and high-quality practice and professional development opportunities.

The NDHS developed a framework to assess mHealth apps, consulting health professionals, consumers, First Nations Peoples and specialty groups across all data sharing levels, and support informed decisions regarding credibility by developers, consumers and healthcare professionals.[96] The assessment follows a triage, assess, publish and re-assess model. The proposed steps include establishing governance arrangements to oversee operations and future modifications.[101

ELECTRONIC HEALTH RECORD (EHR)

The EHR is a digital space that allows access to health information about patients.[99-102] Australia's national EHR, My Health Record (MHR) is actively used in 91% of public hospitals and 53% of private hospitals.[103]

Benefits.
Digitising health records improves quality of care and reduces costs via clinical decision support (CDS) tools, computerised physician order entry (CPOE) systems, and health information exchanges (HIE).[104] CDS systems integrating AI technologies can improve patient outcomes by extracting key findings and

refining treatment plans to improve adherence to best practice guidelines.[105-110] CPOE systems allow clinical orders to be efficiently entered, minimising missing information and providing built-in safety checks.[108-112] HIE enables secure sharing of patient-level electronic health information between organisations, improving interoperability.[113] For hospital management, EHR can facilitate improved resource allocation.[102,104]

Patient access to EHRs strengthens trust in patient-provider relationships by empowering individuals to engage with healthcare.[114] However, patients with poor digital literacy may struggle to navigate complex EHRs, potentially exacerbating health disparities.[115]

Challenges.
Several studies demonstrate temporary losses in productivity as staff move from paper-based to EHR systems.[116-120] System downtime forces healthcare workers to switch between systems, increasing risk of iatrogenic harm.[121] Errors may still persist in EHR due to manual error or discrepancies in documentation standards.[104,121] The lack of uniform EHR standards across hospitals creates interoperability issues, with patients who frequently move between institutions at risk of discontinuous care.[122]

EHR poses privacy risks through susceptibility to data breaches, which can harm patients physically, mentally and financially.[123-125] Distrust from patients can also engender purposeful withholding of information. Concerns about lack of informed consent for data storage, unauthorised access, and data breaches are currently being addressed in NDHS implementations.[126]

MY HEALTH RECORD (MHR)

The MHR system, Australia's national EHR, experienced recent reforms to address previous limited effectiveness.[127] The 2026 legislation 'Modernising My Health Record' mandates that pathology and imaging service providers upload results and health information from July 2026 with planned expansion to care plans and medication management to reduce fragmentation and incomplete patient records and decrease duplicate testing.[127-131]

As a patient-centred system, individuals control document sharing and restrict provider access to and protect information with sensitive data flags.[132] Individuals who opted out of the MHR, were more likely to have multiple health conditions or STI related concerns, limiting benefits for patients with complex conditions and requiring multi provider care.[132-134] Barriers are also experienced by First Nations People and rural community groups including digital access barriers, historical mistrust of government-managed health systems, lower digital literacy limiting awareness and use of privacy controls.[135]

Proposed next steps include:

- Adopt additional granular consent mechanisms for sensitive details surrounding STIs, sex work and sexual orientation ensuring they are

automatically protected and only shared with explicit patient consent.[133]

- Increase investment in community education on improvements and how they are supported navigating the MHR.[135]
- Partner with Aboriginal Community Controlled Health Organisations (ACCHOs) to establish appropriate education, increase awareness of privacy controls and assist individuals in navigating the MHR system to improve trust, cultural safety and credibility of the system.[135,136]

WEARABLES

Definitions and Overviews.

Wearable health technologies are electronic devices that collect physiological and behavioural health data, and are often integrated with smartphone applications to interpret results, monitor trends, and facilitate behavioural change.[137] AI has expanded wearable technologies through analysis of sensor-generated data, supporting disease monitoring and early detection of physiological abnormalities. However, limitations in clinical validation and workflow integration limit clinical implementation.[137] Although wearables can enable healthier lifestyle behaviours, they are not recommended for diagnosing high-risk clinical events due to concerns regarding disease sensitivity and potential harm.[138]

Equity, Accessibility, and Rural Health.

Equity considerations remain important among remote, older adults, and digitally underserved populations. Barriers include digital literacy, device costs and internet connectivity. Facilitators include user-centred design, culturally appropriate training, technical support, clinician endorsement, and integration of wearables into existing models of care.[139] Research involving older Indigenous Australians in remote settings found wearable health devices to be acceptable and feasible despite environmental and connectivity challenges, participants reporting feelings of comfort, safety, and convenience.[140]

Clinical Applications and Remote Monitoring.

Wearable technologies are increasingly used for rehabilitation, monitoring glucose, mobility, falls, and physiological mental health changes.[137] Wearables also support remote patient monitoring and hospital-at-home models. They may additionally support postoperative recovery, detection of deterioration, and patient self-management, although evidence regarding effectiveness continues to vary across clinical settings and patient populations.[137]

Australian Guidelines and Future Implementation.

In Australia, clinical wearable medical devices must undergo regulatory approval by the TGA.[141] Key risks include privacy and security breaches during data transmission and storage.[142] The NDHS Delivery Roadmap 2025 emphasises that emerging digital technologies must remain safe, inclusive, and ethically regulated.[143] Improving digital literacy among patients, involving clinicians in system design and improving accessibility are vital for successful implementation.[144,145]

For More Information

Artificial Intelligence and Digital Innovation Definitions:

Generative AI refers to a class of artificial intelligence models capable of producing new content including text and images based on patterns learned from existing datasets In clinical contexts, these systems are increasingly being explored, assisting with tasks such as documentation, preliminary medical imaging analysis and workflow optimisation. Large Language Models (LLMs) refer to AIs that can understand and generate human-like text based on input [44].

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